If you work in this country, you should get paid enough so you don't have to live in poverty.

Again, vocational education is important, but we need to fund these programs. That is something that this Republican Congress has failed to do.

Mr. Speaker, I yield back the balance of my time.

Mr. BISHOP of Utah. Mr. Speaker, in closing, I wish to try and address my remarks to the bill we have before us and hopefully keep them germane to the particular issue we have in front of us.

We have a very good conference report. It is a conference report which is just what a conference report is, a negotiated compromise between both parties and both Houses of this Congress, which means, in essence, we have 535 different opinions and we have compromised down to one bill, which I think satisfies the base needs of all of us, or at least the vast majority of us who are in Congress right now.

This is legislation that reflects legislative priorities as to funding for vocational education.

□ 1045

It provides more funds than perhaps the programs that have been assigned to us by the Constitution would do to this particular body. But it does reflect those priorities.

Mr. Speaker, I urge my colleagues to support this resolution because a ''yes'' vote moves us forward. A ''no'' vote on this resolution would harm kids. Mr. Speaker, I support the resolution and the underlying legislation.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

PROVIDING FOR CONSIDERATION OF H.R. 4157, HEALTH INFORMATION TECHNOLOGY PROMOTION ACT OF 2006

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 952 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 952

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 4157) to amend the Social Security Act to encourage the dissemination, security, confidentiality, and usefulness of health information technology. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour, with 35 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce and 25 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means. After general debate the bill shall be considered for amendment under the five-minute rule. In lieu of the amendments recommended by the Committees on Energy and Commerce and Ways and Means now printed in the bill, the amendment in the nature of a substitute printed in part A of the report of the Committee on Rules accompanying this resolution, modified by the amendment printed in part B of such report, shall be considered as adopted in the House and in the Committee of the Whole. The bill, as amended, shall be considered as the original bill for the purpose of further amendment under the five-minute rule and shall be considered as read. All points of order against provisions in the bill, as amended, are waived. Notwithstanding clause 11 of rule XVIII, no amendment to the bill, as amended, shall be in order except those printed in part C of the report of the Committee on Rules. Each such amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. All points of order against such amendments are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill, as amended, to the House with such further amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

SEC. 2. After passage of H.R. 4157, it shall be in order to consider in the House S. 1418. All points of order against the Senate bill and against its consideration are waived. It shall be in order to move to strike all after the enacting clause of the Senate bill and to insert in lieu thereof the provisions of H.R. 4157 as passed by the House. All points of order against that motion are waived. If the motion is adopted and the Senate bill, as amended, is passed, then it shall be in order to move that the House insist on its amendments to S. 1418 and request a conference with the Senate thereon.

SEC. 3. House Resolution 924 is laid upon the table.

The SPEAKER pro tempore. The gentleman from Florida (Mr. LINCOLN DIAZ-BALART) is recognized for 1 hour.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentlewoman from California (Ms. MATSUI), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

(Mr. LINCOLN DIAZ-BALART of Florida asked and was given permission to revise and extend his remarks.)

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, the rule provides 1 hour of general debate with 35 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce and 25 minutes equally divided and controlled by the chairman and ranking minority member on the Committee on Ways and Means. The rule also provides one motion to recommit with or without instructions.

Mr. Speaker, the information age has greatly changed our economy by bringing about increased efficiencies in productivity. Virtually every sector of our economy benefits from the use of new information technologies.

Right here in Congress, for example, the use of technology has opened up access to the workings of our democracy like never before. Technology allows our constituents to quickly view the status of a bill or to look up our voting records.

Mr. Speaker, the health care industry has not fully embraced the advantages and benefits of information technology. According to a study by the RAND Corporation, only 15 percent of physicians and 20 percent of hospitals use computerized patient files.

Broad use of information technology in the health care system would certainly improve the quality and efficiency of health care delivery.

The use of health information technology is increasingly necessary to deliver the best care possible to individuals with chronic illnesses. The use of health care IT would also promote interoperability between providers and payers.

Efficiencies from coordinated development of health IT will accelerate and advance private and public efforts to improve quality, lower costs, reduce fraud and abuse, and promote the coordination of care. The synergy of these efficiencies will help achieve better health outcomes for patients.

The Health Information Technology Promotion Act, which we bring to the floor today, will improve the quality of care Americans receive through national adoption of electronic medical records and e-prescribing systems.

The legislation promotes the adoption and use of interoperable health information technology that prevents medical and prescription errors and costly duplicate tests, eliminates lost medical records, simplifies our administrative system, and improves medical care and the treatment of chronic illnesses.

The legislation we bring to the floor today provides grants for the use of health information technology to coordinate care among the uninsured and to implement technology in small physician practices. It also updates diagnostic coding, systems for the digital age, and provides for an expedited process to update standards.

Mr. Speaker, this legislation was introduced by Congresswoman NANCY JOHNSON, my dear friend, who is a true expert in the field of health care. It was reported out of the House Energy and Commerce Committee. We believe it is time that the health care industry moves to a digital future, and this legislation is an important step in seeing that to reality.

Mr. Speaker, I would like to thank Congresswoman JOHNSON and Chairman BARTON and Chairman THOMAS for

their leadership on this important issue. I urge my colleagues to support the rule that brings this legislation forth as well as the underlying legislation.

Mr. Speaker, I reserve the balance of my time.

Ms. MATSUI. Mr. Speaker, I thank my good friend, the gentleman from Florida, for yielding me time; and I yield myself such time as I may consume.

(Ms. MATSUI asked and was given permission to revise and extend her remarks.)

Ms. MATSUI. Mr. Speaker, every Member of Congress recognizes the importance of health information technology. It holds the potential to save lives by reducing medical errors, and it can make our health care system more efficient by providing better care while keeping costs down.

In short, we could revolutionize the way our health care is delivered. What exactly is the potential? Physicians could have access to every relevant part of a patient's medical history at the precise moment a life-or-death decision needs to be made.

It is the tens of thousands of lives saved because of fewer medical errors. It means the newest ''Physicians Desks Reference'' and the most cutting-edge medical research on a hand-held device that a doctor can have at the patient's bedside.

This is not pie-in-the-sky ambition. Some health care leaders have already begun to adopt these ideas with great success. In the year 2000, the Veterans Administration implemented the most advanced electronic medical records system in the United States.

A recent article in Business Week noted that ''while studies show that 3 to 8 percent of the Nation's prescriptions are filed erroneously, the VA's prescription accuracy rate is greater than 99.99 percent, a level most hospitals only dream about.''

It should not be surprising that while many patients lost their paper medical records in the terrible aftermath of Hurricane Katrina, veterans did not. Veterans living in New Orleans were able to access their medical records at other VA hospitals because of health information technology.

Another example comes from my hometown of Sacramento. The UC Davis Medical Center has a world-renowned telemedicine program which connects patients in 80 rural areas across California to an immense amount of specialty care in Sacramento.

Let me tell you the story of Levi, a child who lives on a ranch in a nine-person town 60 miles north of Sacramento. After accidentally suffering third-degree burns on his leg, his parents took him to the closest hospital. Because of UC Davis's telemedicine program, Levi was treated by one of the few pediatric burn specialists in this country remotely from Sacramento.

Information technology could make this amazing program even better. Widespread adoption of this technology would enhance this expert advice by allowing the rural doctor to send Levi's medical history to the specialists at UC Davis instantly.

UC Davis has begun to implement electronic medical records, but many of these outlying areas cannot afford this technology without seed money.

That is the goal of establishing a national health information infrastructure. But we know such a comprehensive program isn't cheap. It could cost individual hospitals several million dollars and individual physicians $20,000 or $30,000 apiece.

So the issue needs more than Federal guidelines. It needs Federal financial support, seed money in a sense. Unfortunately, the bill we will debate today falls far short. It provides only $40 million in Federal grants. In a $1.3 trillion health care system, this does not even scratch the service.

In fact, the nonpartisan Congressional Budget Office, CBO, says the bill, as written, will do almost nothing to encourage health information technology. According to their analysis, it will not significantly influence the rate at which health information technology is adopted, nor will it ensure better quality technology.

Democrats have proposed a more effective proposal, backed by Federal seed money, just like the bipartisan Senate bill does. We would also add new privacy laws to strengthen patient protections. This would prepare us for the health information age.

It would require patients to give their consent before their health information could be shared with other people. It also requires data encryption to protect these health information networks from hackers.

It sides with patients by making sure that everyone, every individual and every health entity, complies with privacy protections.

Unfortunately, late last night the Rules Committee denied the House the opportunity to debate the Democratic alternative on the floor. As a result, I will be urging my colleagues to defeat the previous question and defeat this rule.

□ 1100

Mr. Speaker, information technology will bring our Nation's health care system tremendous benefits, but the devil is often in the details. This technology will not install itself. It will spread only with the right kind of Federal leadership. So, I urge my colleagues to support the Democratic substitute and support the responsible approach to national health information technology.

Mr. Speaker, I reserve the balance of my time.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I reserve the balance of my time.

Ms. MATSUI. Mr. Speaker, I yield 2 minutes to my good friend, the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. I thank my colleague for yielding.

Mr. Speaker, I rise in strong opposition to the rule for H.R. 4157. As a nurse, of course I want to see the expanded use of health information technology, such as electronic medical records. Expanded use of health IT holds great promise for facilitating better care, reducing medical errors, and eliminating burdensome paperwork, but the bill before us today has a glaring omission: It has no privacy protection for patients.

A privacy amendment I sponsored along with Representatives MARKEY, EMANUEL, DOGGETT, and KENNEDY was killed by the Republicans on the Rules Committee even though there is bipartisan support for this measure. As usual, the House won't be voting on a measure because the Republican leadership opposes it but is afraid that if we debate and vote on it in the House, they might lose the vote.

Let's be clear, there is no comprehensive privacy protection in this bill before us today. That means your personal sensitive health information is vulnerable. That means there is no recourse you could take to hold individuals accountable if they improperly obtain or disclose your most personal private information.

Opponents of privacy protection will argue that current HIPAA regulations are adequate. That argument is flawed. The lack of enforcement of privacy protections is widely known in the health community. Because of that, surveys show fewer entities are complying with HIPAA because they fear no consequences for privacy violations. And, these violations are occurring. Our privacy amendment would have guaranteed that you would be notified if your information is improperly disclosed and it would have allowed you recourse.

The amendment should have been made in order because its provisions are essential to protecting patients' rights during the nationwide adoption of health information technology. So I urge my colleagues to oppose the rule until we are allowed to consider a bill that protects our rights as patients and, indeed, the rights of all patients.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I reserve the balance of my time.

Ms. MATSUI. Mr. Speaker, I yield 3 minutes to the gentlewoman from California, my good friend (Ms. ESHOO).

Ms. ESHOO. I thank our distinguished member of the Rules Committee.

Mr. Speaker, I rise this morning in opposition to the rule and in opposition to the bill, and I want to state very clearly why. I believe that this bill is deeply deficient. And I am very disappointed because I had high hopes for this bill. At one time I was a cosponsor of it, but I removed my name from the bill when I saw what the deficiencies were and that the majority would not address them.

My colleague, Mrs. CAPPS, has just eloquently outlined the deep deficiency relative to privacy. If you ask any American about privacy and if they want it protected in their financial records and their medical records, there will be a resounding yes. This bill has no protection for the American people relative to privacy.

The second point, which is really a shame, that an HIT, health information technology bill, does not assure interoperability. My colleague from Florida mentioned this in his statement. There isn't going to be any point, it won't matter if every doctor, every hospital in our country has invested in robust IT technology if they can't communicate with one another. What this bill provides is that down the road, down the road 3 years, 5 years there may be interoperability. Does the majority not understand that in the market in terms of information technology that products change 6 months, 8 months. And so there isn't anything in the bill that assures that interoperability is going to take place.

I offered an amendment in the Rules Committee that was turned down. It ensured that purchasers and vendors in the HIT marketplace will be able to rely on representations about compliance with the interoperability standards adopted under this legislation by creating a voluntary certification process for HIT products.

Dr. David Brailer, the first national coordinator for health IT, said last month that if the government does not immediately employ interoperability standards in its purchasing, the adoption of the standards in the marketplace could take 5 to 7 years instead of 1 or 2 to implement.

So this is a wonderful vehicle, it sounds terrific, it is all shiny and waxed up. Everyone looks at it and says, doesn't this look terrific? I hate to dampen your spirits, but there isn't any gas in the engine and this dog is not going to hunt. It is an opportunity that has been squandered, and I reluctantly oppose the rule and the bill.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I reserve the balance of my time.

Ms. MATSUI. Mr. Speaker, I yield 4½ minutes to my good friend the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. I thank the gentlewoman. The great Irish poet, William Butler Yeats, used to say that, ''In dreams begins responsibility.''

There is a dream here that we can place all of the medical records of all Americans online, that can have an IT world where for the sake of patients we can move medical information across hundreds, thousands of miles to save the patient's life. And that is great. That is a great dream. But that dream will replace something that exists today, which is that when each of us goes in to visit a physician, when our family member's private medical records are inside a cabinet with a nurse that has a key that can open that drawer and pull out your family's private records, that you have confidence that that physician, that that nurse is not going to tell everyone else in town what the secrets are of your husband, of your wife, of your child, of your mother or your father, that there are protections, that privacy is sacred, that your physician is a privacy keeper and not a data mining information seeker.

As we move to this new era where information is being abrogated by medical insurance companies, HMOs, medical consultants, medical data mining companies, that we build in at the beginning of this era the privacy protections, the guarantees that each individual's family has a right to say, ''I don't want my family's psychiatric records, I don't want my child's medical records, I don't want this information, mental health, prescription drug records or other personal medical data put online without my permission. I just don't want it spread around without my permission, without my family's permission.''

So I went to the Rules Committee, and Congressmen KENNEDY, EMANUEL, DOGGETT, CAPPS, we requested that we have that debate here on the House floor, and the Republican leadership said no. No, we are just going to listen to the insurance industry. We are going to listen to the HMO industry. We are not going to allow a debate on medical privacy on the House floor as we move to this new era.

And I will tell you something, this is about as serious an issue as people can imagine affecting their family, and there are 84 million good reasons why we should have this debate: Because 84 million is the number of times over the last 2 years we have seen the compromise of the financial records of American people, from the ChoicePoint scandal, these you can go right down the whole line. But now we have the big enchilada, and that is the medical records of people's families.

And, by the way, this is not an issue that divides along Democrat or Republican lines, liberal or conservative lines. It polls out at over 80 percent of all Americans that want the right to be able to protect their own personal medical records.

So what has happened then? Well, what has happened is the Republican party is ignoring the fact that it polls out at 80 percent Democrat and Republican. And what they decided to do is to side with the insurance industry, side with the HMOs who want to use our personal medical records as a product, as something that allows them to go through and to identify useful information for the insurance industry, for HMOs.

William Butler Yeats once said that, ''In dreams begins responsibility.'' That should happen here on the House floor today. But the Republicans are abdicating that responsibility. They are saying, let's give the HMOs, let's give the data miners, let's give these consultants, let's give these insurance companies what they want now, and we will come back and revisit the privacy issue after there is a catastrophic compromise of privacy affecting millions of American families. That is not exercising the responsibility that should be exercised. Vote ''no'' on this rule. Vote ''no'' on this bill.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, Yeats wrote many wonderful, beautiful things. We in the Rules Committee deal with reality. The reality of the rule that we bring to the floor today in order to bring the underlying legislation on information technology for the health care industry brings forth and authorizes six amendments, six amendments to be debated by this House.

Our function is to listen, and we listened hour after hour after hour after hour, with great respect, in the Rules Committee to our colleagues who come forth with multiple ideas. We bring forth six amendments for the consideration of this entire body today. Of the six amendments, four are authored by Members of the opposition, of the Democrat Party; one is a bipartisan amendment, Republican and Democrat; and one is a Republican amendment. We think we are being fair, Mr. Speaker.

So we seek not to bring forth the beauty of Yeats, but in dealing with reality, in dealing with listening to hours of testimony from our colleagues, in authorizing four amendments of Democrats, one of a Republican, one of a bipartisan nature, we think we have done a fair job. And that is what we have authorized for consideration, for debate by this House in the rule that brings forward this very important legislation that we will be hearing about, and we will be hearing about as the authors of the legislation explain it in detail.

I am very proud to be a supporter of the legislation. It is important that information technology reach as much of the health care industry, patients, as possible so that mistakes are avoided, and so that access to the great advances of technology are made available to the largest number of people. There are important issues that this legislation is going to be bringing forth and dealing with and that this debate will entail.

□ 1115

Now, obviously in order for debate to begin, we have to pass the rule which sets the terms of the debate. We are proud of those terms of debate, the extraordinarily fair nature of the terms of that debate. As I have said, Mr. Speaker, four amendments made in order are Democrat amendments, one is a Republican amendment, one is a bipartisan amendment.

Mr. Speaker, I reserve the balance of my time.

Ms. MATSUI. Mr. Speaker, I yield 4 minutes to my good friend, the gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Speaker, I thank the gentlewoman for yielding me this time.

Mr. Speaker, I have been working on this issue for several years. I have met with countless groups across this country. I have forged bipartisan relationships to bring a solid piece of legislation before this House, and today I am disappointed to say that this legislation does not meet the mark.

The Congressional Budget Office itself has said this legislation, quote, would not significantly affect either the rate at which the use of health technology will grow or how well that technology will be designed and implemented.

So what is the point? If we cannot get this technology in the hands of the providers, what are we doing here? This legislation does not require us to adopt standards that are interoperability standards for all on a date certain. We need to do this within the next year and a half. We could do this within the next year.

We should be taking this opportunity and passing real health care information technology legislation; but, instead, we are passing a shadow of a bill that misses the opportunity to pass real opportunities for savings, both in people's lives and in countless dollars across this country.

Mr. Speaker, we spend twice what every other industrialized nation spends on health care. It is the worst system when it comes to employers paying incredible premiums. We see employees paying incredible premiums. We are seeing providers complain. Nobody is happy with the current health care system; and, yet, what are we doing about it? We are missing the opportunity today.

We could provide technology today that would help us implement quality standards so that when you are being treated, whether it is in Iowa or Rhode Island or New York, you get the same standard of care. But are those quality provisions in this bill? No, they are not.

We can make sure that we have provisions in this bill to have the privacy protections in place, as Mr. MARKEY just talked about. Are they in this bill? No, they are not.

How can we have an IT bill that does not set a date certain for technology, that does not have quality provisions in place so that we can use technology to bring the best and evidence-based medicines to the bedside? How can we not have provisions to protect privacy in an age when we are going electronic in health care records?

Mr. Speaker, this bill falls way short of our opportunities to make a fundamental change in our health care system. I am sorry I am going to have to oppose this rule. I am going to have to oppose this bill because I think it falls way short of the opportunities we have been given to make the most of this chance to get a better health care system today. We are squandering that chance. For that reason, I will oppose the rule and oppose the underlying bill.

Ms. MATSUI. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am asking Members to vote ''no'' on the previous question so I can amend this rule and allow the House to consider the Dingell-Rangel substitute. This substitute was offered in the Rules Committee last night, but was blocked on a straight party-line vote.

Mr. Speaker, I ask unanimous consent to print the text of the amendment and extraneous materials immediately prior to the vote on the previous question.

The SPEAKER pro tempore (Mr. PRICE of Georgia). Is there objection to the request of the gentlewoman from California?

There was no objection.

Ms. MATSUI. Mr. Speaker, I believe the Dingell-Rangel substitute offers Members a far better choice than the underlying bill.

This substitute is based on the bipartisan bill that was introduced by Senators FRIST, ENZI, KENNEDY and CLINTON and passed unanimously by the Senate last November. This substitute also contains important privacy protections necessary in this new electronic world.

The Democratic substitute requires the Federal Government to take a leading role in the adoption of standards for technology and adopting technology that will permit providers and others to communicate to each other electronically. This substitute will provide $257 million in grants and loans for providers and regional collaboratives to buy and implement health information technology.

This substitute also provides privacy protections beyond those in current law to ensure that patients' health information is secure. It requires that all individuals and entities with access to personal health information must comply with privacy protections to maintain patient confidentiality. The substitute also requires data encryption to prevent security breaches and the notification of patients in case of a security breach. Finally, it allows patients to seek redress when their privacy is breached.

I want Members to be aware that a ''no'' vote will not stop us from considering H.R. 4157. A ''no'' vote will simply allow the Dingell-Rangel substitute to be considered by this House by an up-or-down vote.

Vote ''no'' on the previous question so we can consider this important and responsible substitute.

Mr. Speaker, I yield back the balance of my time.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield myself such time as I may consume.

I thank all of my colleagues who have participated in this very interesting debate today. Much has been made by opponents of the legislation of arguments with regard to privacy protections. I think it is relevant and should be pointed out that the very significant and extensive privacy protections contained in the Health Insurance Portability and Accountability Act of 1996 are not reduced in any way by this legislation that we bring forth to the floor today.

In fact, the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, the National Mental Health Association have said in a letter to the Energy and Commerce Committee, ''The Energy and Commerce language ensures that the current protections in the Health Insurance Portability and Accountability Act of 1996 are maintained, and we wish to commend the approach to privacy protections that the Energy and Commerce Committee proposes to take.''

I mean, it is relevant to point this out because much has been said that would seem or could be interpreted to contradict what I have just read from the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, the National Mental Health Association, very responsible entities that look out for the interests of many citizens who receive health care.

So, Mr. Speaker, urging the support of the underlying legislation, I also urge all of my colleagues to support this rule, which is very fair, makes more than twice as many amendments by Democrats than by Republicans in order. It is precisely in our interest to go the extra mile for fairness.

Mr. DINGELL. Mr. Speaker, I rise in strong opposition to this rule. There once was a time when we considered legislation under open rules. Any Member could offer an amendment. That was the way I, as chairman of the Committee on Energy and Commerce, brought bills to the House floor.

Eventually amendments were limited, perhaps under the guise of efficiency. But certainly the minority should be allowed to offer an alternative. Democrats brought an alternative to the Committee on Rules. It was supported by every Democrat on our committee.

It was not a radical alternative. It was identical to the bill that passed the Senate unanimously, with the addition of language to protect patient privacy. Yet this rule blocks the offering of our proposal.

If my Republican colleagues disagree with this substitute, fine—vote against it, but don't hide behind a rule that prevents us from offering it.

If we had an open rule, we could fairly debate this important issue. All of us want to improve health information technology. One hundred Senators voted for a bill to do so, but under this closed rule, if a Member of the House wanted to offer that Senate bill, which was sponsored by Republican Majority Leader FRIST, along with Senator ENZI, KENNEDY, and CLINTON, he or she could not do so.

That's right—my rubber stamp Republican colleagues are about to pass a rule that makes sure that a bill that passed unanimously in the Senate cannot even get a vote in the House. It is a closed rule and that

means only amendments that the Republican leaders can accept will get a vote.

I have read that many of my Republican colleagues are trying to distance themselves from the policies of the House Republican leadership. Well, here is your chance. Reject a rule that prohibits Members from offering a substitute that consists of a bill passed unanimously by 100 Senators. Reject a rule that prohibits an amendment dealing with the privacy of personal medical records.

But we know the fix is in. Why else did not a single Republican Member go to the Rules Committee to ask for a rule to allow them to offer a bill supported by 100 Senators? Why else did not a single Republican Member care to offer an amendment to protect the privacy of medical records?

A vote for this closed rule is, quite simply, a vote against bipartisanship. It is a vote against privacy protections for Americans. And it is a vote against getting a bill signed into law this Congress.

The material previously referred to by Ms. MATSUI is as follows:

PREVIOUS QUESTION FOR H. RES. 952—H.R. 4157 HEALTH INFORMATION TECHNOLOGY PROMOTION ACT OF 2006

At the end of the resolution, add the following:

SEC. 4. Notwithstanding any other provision of this resolution the amendment specified in section 5 shall be in order as though printed after the amendment numbered 6 in the report of the Committee on Rules if offered by Representative Dingell of Michigan or Representative Rangel of New York or a designee. That amendment shall be debatable for 30 minutes equally divided and controlled by the proponent and an opponent.

SEC. 5. The amendment referred to in section 2 is as follows:

AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4157, AS REPORTED

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Wired for Health Care Quality Act''.

SEC. 2. IMPROVING HEALTH CARE QUALITY, SAFETY, AND EFFICIENCY.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXIX—HEALTH INFORMATION TECHNOLOGY AND QUALITY

''SEC. 2901. DEFINITIONS.

''In this title:

''(1) HEALTH CARE PROVIDER.—The term 'health care provider' means a hospital, skilled nursing facility, home health entity, health care clinic, federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a practitioner (as defined in section 1842(b)(18)(CC) of the Social Security Act), a health facility operated by or pursuant to a contract with the Indian Health Service, a rural health clinic, and any other category of facility or clinician determined appropriate by the Secretary.

''(2) HEALTH INFORMATION.—The term 'health information' has the meaning given such term in section 1171(4) of the Social Security Act.

''(3) HEALTH INSURANCE PLAN.—The term 'health insurance plan' means—

''(A) a health insurance issuer (as defined in section 2791(b)(2));

''(B) a group health plan (as defined in section 2791(a)(1)); and

''(C) a health maintenance organization (as defined in section 2791(b)(3)).

''(4) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' has the meaning given such term in section 1171 of the Social Security Act.

''(5) LABORATORY.—The term 'laboratory' has the meaning given that term in section 353.

''(6) PHARMACIST.—The term 'pharmacist' has the meaning given that term in section 804 of the Federal Food, Drug, and Cosmetic Act.

''(7) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term 'qualified health information technology' means a computerized system (including hardware and software) that—

''(A) protects the privacy and security of health information;

''(B) maintains and provides permitted access to health information in an electronic format;

''(C) incorporates decision support to reduce medical errors and enhance health care quality;

''(D) complies with the standards adopted by the Federal Government under section 2903; and

''(E) allows for the reporting of quality measures under section 2908.

''(8) STATE.—The term 'State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF HEALTH INFORMATION TECHNOLOGY.

''(a) OFFICE OF NATIONAL HEALTH INFORMATION TECHNOLOGY.—There is established within the Office of the Secretary an Office of the National Coordinator of Health Information Technology (referred to in this section as the 'Office'). The Office shall be headed by a National Coordinator who shall be appointed by the Secretary and shall report directly to the Secretary.

''(b) PURPOSE.—It shall be the purpose of the Office to coordinate with relevant Federal agencies and private entities and oversee programs and activities to develop a nationwide interoperable health information technology infrastructure that—

''(1) ensures that patients' individually identifiable health information is secure and protected;

''(2) improves health care quality, reduces medical errors, and advances the delivery of patient-centered medical care;

''(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;

''(4) ensures that appropriate information to help guide medical decisions is available at the time and place of care;

''(5) promotes a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes;

''(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;

''(7) improves public health reporting and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;

''(8) facilitates health research; and

''(9) promotes prevention of chronic diseases.

''(c) DUTIES OF THE NATIONAL COORDINATOR.—The National Coordinator shall—

''(1) serve as the principal advisor to the Secretary concerning the development, application, and use of health information technology, and coordinate and oversee the health information technology programs of the Department;

''(2) facilitate the adoption of a nationwide, interoperable system for the electronic exchange of health information;

''(3) ensure the adoption and implementation of standards for the electronic exchange of health information to reduce cost and improve health care quality;

''(4) ensure that health information technology policy and programs of the Department are coordinated with those of relevant executive branch agencies (including Federal commissions) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability;

''(5) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and private parties of interest, including consumers, payers, employers, hospitals and other health care providers, physicians, community health centers, laboratories, vendors and other stakeholders;

''(6) advise the President regarding specific Federal health information technology programs; and

''(7) prepare the reports described under section 2903(i) (excluding paragraph (4) of such section).

''(d) DETAIL OF FEDERAL EMPLOYEES.—

''(1) IN GENERAL.—Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

''(2) EFFECT OF DETAIL.—Any detail of personnel under paragraph (1) shall—

''(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and

''(B) be in addition to any other staff of the Department employed by the National Coordinator.

''(3) ACCEPTANCE OF DETAILEES.—Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Office, regardless of whether such efforts were carried out prior to or after the enactment of this title.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2007, $5,000,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2011.

''SEC. 2903. AMERICAN HEALTH INFORMATION COLLABORATIVE.

''(a) PURPOSE.—The Secretary shall establish the public-private American Health Information Collaborative (referred to in this section as the 'Collaborative') to—

''(1) advise the Secretary and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure;

''(2) serve as a forum for the participation of a broad range of stakeholders to provide input on achieving the interoperability of health information technology; and

''(3) recommend standards (including content, communication, and security standards) for the electronic exchange of health information (including for the reporting of quality data under section 2908) for adoption by the Federal Government and voluntary adoption by private entities.

''(b) COMPOSITION.—

''(1) IN GENERAL.—The Collaborative shall be composed of members of the public and private sectors to be appointed by the Secretary, including representatives from—

''(A) consumer or patient organizations;

''(B) organizations with expertise in privacy and security;

''(C) health care providers;

''(D) health insurance plans or other third party payors;

''(E) information technology vendors; and

''(F) purchasers or employers.

''(2) PARTICIPATION.—In appointing members under paragraph (1), and in developing the procedures for conducting the activities of the Collaborative, the Secretary shall ensure a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Collaborative.

''(3) TERMS.—Members appointed under paragraph (1) shall serve for 2 year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve for not to exceed 180 days after the expiration of such member's term or until a successor has been appointed.

''(4) OUTSIDE INVOLVEMENT.—With respect to the functions of the Collaborative, the Secretary shall ensure an adequate opportunity for the participation of outside advisors, including individuals with expertise in—

''(A) health information privacy;

''(B) health information security;

''(C) health care quality and patient safety, including individuals with expertise in utilizing health information technology to improve health care quality and patient safety;

''(D) data exchange; and

''(E) developing health information technology standards and new health information technology.

''(c) RECOMMENDATIONS AND POLICIES.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall recommend to the Secretary uniform national policies for adoption by the Federal Government and voluntary adoption by private entities to support the widespread adoption of health information technology, including—

''(1) protection of individually identifiable health information through privacy and security practices;

''(2) measures to prevent unauthorized access to health information, including unauthorized access through the use of certain peer-to-peer file-sharing applications;

''(3) methods to notify patients if their individually identifiable health information is wrongfully disclosed;

''(4) methods to facilitate secure patient access to health information;

''(5) fostering the public understanding of health information technology;

''(6) the ongoing harmonization of industry-wide health information technology standards;

''(7) recommendations for a nationwide interoperable health information technology infrastructure;

''(8) the identification and prioritization of specific use cases for which health information technology is valuable, beneficial, and feasible;

''(9) recommendations for the establishment of an entity to ensure the continuation of the functions of the Collaborative; and

''(10) other policies (including recommendations for incorporating health information technology into the provision of care and the organization of the health care workplace) determined to be necessary by the Collaborative.

''(d) STANDARDS.—

''(1) EXISTING STANDARDS.—The standards adopted by the Consolidated Health Informatics Initiative shall be deemed to have been recommended by the Collaborative under this section.

''(2) FIRST YEAR REVIEW.—Not later than 1 year after the date of enactment of this title, the Collaborative shall—

''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information;

''(B) identify deficiencies and omissions in such existing standards; and

''(C) identify duplication and overlap in such existing standards;

and recommend new standards and modifications to such existing standards as necessary.

''(3) ONGOING REVIEW.—Beginning 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall—

''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information;

''(B) identify deficiencies and omissions in such existing standards; and

''(C) identify duplication and overlap in such existing standards;

and recommend new standards and modifications to such existing standards as necessary.

''(4) LIMITATION.—The standards and timeframe for adoption described in this section shall be consistent with any standards developed pursuant to the Health Insurance Portability and Accountability Act of 1996.

''(e) FEDERAL ACTION.—Not later than 90 days after the issuance of a recommendation from the Collaborative under subsection (d)(2), the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies, as determined appropriate by the Secretary, shall jointly review such recommendations. If appropriate, the Secretary shall provide for the adoption by the Federal Government of any standard or standards contained in such recommendation.

''(f) COORDINATION OF FEDERAL SPENDING.—

''(1) IN GENERAL.—Not later than 1 year after the adoption by the Federal Government of a recommendation as provided for in subsection (e), and in compliance with chapter 113 of title 40, United States Code, no Federal agency shall expend Federal funds for the purchase of any new health information technology or health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information that is not consistent with applicable standards adopted by the Federal Government under subsection (e).

''(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed to restrict the purchase of minor (as determined by the Secretary) hardware or software components in order to modify, correct a deficiency in, or extend the life of existing hardware or software.

''(g) COORDINATION OF FEDERAL DATA COLLECTION.—Not later than 3 years after the adoption by the Federal Government of a recommendation as provided for in subsection (e), all Federal agencies collecting health data for the purposes of quality reporting, surveillance, epidemiology, adverse event reporting, research, or for other purposes determined appropriate by the Secretary, shall comply with standards adopted under subsection (e).

''(h) VOLUNTARY ADOPTION.—

''(1) IN GENERAL.—Any standards adopted by the Federal Government under subsection (e) shall be voluntary with respect to private entities.

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require that a private entity that enters into a contract with the Federal Government adopt the standards adopted by the Federal Government under this section with respect to activities not related to the contract.

''(3) LIMITATION.—Private entities that enter into a contract with the Federal Government shall adopt the standards adopted by the Federal Government under this section for the purpose of activities under such Federal contract.

''(i) REPORTS.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, on an annual basis, a report that—

''(1) describes the specific actions that have been taken by the Federal Government and private entities to facilitate the adoption of an interoperable nationwide system for the electronic exchange of health information;

''(2) describes barriers to the adoption of such a nationwide system;

''(3) contains recommendations to achieve full implementation of such a nationwide system; and

''(4) contains a plan and progress toward the establishment of an entity to ensure the continuation of the functions of the Collaborative.

''(j) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Collaborative, except that the term provided for under section 14(a)(2) shall be 5 years.

''(k) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Collaborative, regardless of whether such efforts were carried out prior to or after the enactment of this title.

''(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $4,000,000 for fiscal year 2007, $4,000,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2011.

''SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF HEALTH INFORMATION STANDARDS.

''(a) IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure uniform and consistent implementation of any standards for the electronic exchange of health information voluntarily adopted by private entities in technical conformance with such standards adopted under this title.

''(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title using the criteria developed by the Secretary under this section.

''(b) CERTIFICATION.—

''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure and certify that hardware and software that claim to be in compliance with applicable standards for the electronic exchange of

health information adopted under this title have established and maintained such compliance in technical conformance with such standards.

''(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1) using the criteria developed by the Secretary under this section.

''(c) OUTSIDE INVOLVEMENT.—The Secretary, through consultation with the Collaborative, may accept recommendations on the development of the criteria under subsections (a) and (b) from a Federal agency or private entity.

''SEC. 2905. PRIVACY AND SECURITY PROTECTIONS.

''(a) IN GENERAL.—The Secretary shall provide for standards for health information technology (as such term is used in this title) that include the following privacy and security protections:

''(1) Except as provided in succeeding paragraphs, each entity must—

''(A) expressly recognize the individual's right to privacy and security with respect to the electronic disclosure of such information;

''(B) permit individuals to exercise their right to privacy and security in the electronic disclosure of such information to another entity by obtaining the individual's written or electronic informed consent, which consent may authorize multiple disclosures;

''(C) permit an individual to prohibit access to certain categories of individuals (as defined by the Secretary) of particularly sensitive information, including data relating to infection with the human immunodeficiency virus (HIV), to mental health, to sexually transmitted diseases, to reproductive health, to domestic violence, to substance abuse treatment, to genetic testing or information, to diabetes, and other information as defined by the Secretary after consent has been provided under subparagraph (B).

''(2) Informed consent may be inferred, in the absence of a contrary indication by the individual—

''(A) to the extent necessary to provide treatment and obtain payment for health care in emergency situations;

''(B) to the extent necessary to provide treatment and payment where the health care provider is required by law to treat the individual;

''(C) if the health care provider is unable to obtain consent due to substantial barriers to communicating with the individual and the provider reasonably infers from the circumstances, based upon the exercise of professional judgment, that the individual does not object to the disclosure or that the disclosure is in the best interest of the individual; and

''(D) to the extent that the information is necessary to carry out or otherwise implement a medical practitioner's order or prescription for health services, medical devices or supplies, or pharmaceuticals.

''(3) The protections must prohibit the improper use and disclosure of individually identifiable health information by any entity.

''(4) The protections must provide any individual a right to obtain damages and other relief against any entity for the entity's improper use or disclosure of individually identifiable health information.

''(5) The protections must require the use of reasonable safeguards, including audit capabilities, encryption and other technologies that make data unusable to unauthorized persons, and other measures, against the risk of loss or unauthorized access, destruction, use, modification, or disclosure of individually identifiable health information.

''(6) The protections must provide for notification to any individual whose individually identifiable health information has been lost, stolen, or used for an unauthorized purpose by the entity responsible for the information and notification by the entity to the Secretary.

''(b) LIST OF ENTITIES.—The Secretary shall maintain a public list identifying entities whose health information has been lost, stolen, or used in an unauthorized purpose as described in subsection (a)(6) and how many patients were affected by such action.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as superseding, altering, or affecting (in whole or in part) any statute, regulation, order, or interpretation in effect in any State that affords any person privacy and security protections greater than that the privacy and security protections described in subsection (a), as determined by the Secretary.

''SEC. 2906. GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.

''(a) COMPETITIVE GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

''(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

''(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(B) submit to the Secretary a strategic plan for the implementation of data sharing and interoperability measures;

''(C) be a—

''(i) not for profit hospital, including a federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act);

''(ii) individual or group practice; or

''(iii) another health care provider not described in clause (i) or (ii);

''(D) adopt the standards adopted by the Federal Government under section 2903;

''(E) implement the measures adopted under section 2908 and report to the Secretary on such measures;

''(F) agree to notify patients if their individually identifiable health information is wrongfully disclosed;

''(G) demonstrate significant financial need; and

''(H) provide matching funds in accordance with paragraph (4).

''(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to facilitate the purchase and enhance the utilization of qualified health information technology systems and training personnel in the use of such technology.

''(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.

''(5) PREFERENCE IN AWARDING GRANTS.—In awarding grants under this subsection the Secretary shall give preference to—

''(A) eligible entities that are located in rural, frontier, and other underserved areas as determined by the Secretary;

''(B) eligible entities that will link, to the extent practicable, the qualified health information system to local or regional health information plan or plans; and

''(C) with respect to an entity described in subsection (a)(2)(C)(iii), a nonprofit health care provider.

''(b) COMPETITIVE GRANTS TO STATES FOR THE DEVELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

''(1) IN GENERAL.—The Secretary may award competitive grants to States for the establishment of State programs for loans to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology.

''(2) ESTABLISHMENT OF FUND.—To be eligible to receive a competitive grant under this subsection, a State shall establish a qualified health information technology loan fund (referred to in this subsection as a 'State loan fund') and comply with the other requirements contained in this section. A grant to a State under this subsection shall be deposited in the State loan fund established by the State. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any State loan fund.

''(3) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) a State shall—

''(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(B) submit to the Secretary a strategic plan in accordance with paragraph (4);

''(C) establish a qualified health information technology loan fund in accordance with paragraph (2);

''(D) require that health care providers receiving such loans—

''(i) link, to the extent practicable, the qualified health information system to a local or regional health information network;

''(ii) consult with the Health Information Technology Resource Center established in section 914(d) to access the knowledge and experience of existing initiatives regarding the successful implementation and effective use of health information technology; and

''(iii) agree to notify patients if their individually identifiable health information is wrongfully disclosed;

''(E) require that health care providers receiving such loans adopt the standards adopted by the Federal Government under section 2903;

''(F) require that health care providers receiving such loans implement the measures adopted under section 2908 and report to the Secretary on such measures; and

''(G) provide matching funds in accordance with paragraph (8).

''(4) STRATEGIC PLAN.—

''(A) IN GENERAL.—A State that receives a grant under this subsection shall annually prepare a strategic plan that identifies the intended uses of amounts available to the State loan fund of the State.

''(B) CONTENTS.—A strategic plan under subparagraph (A) shall include—

''(i) a list of the projects to be assisted through the State loan fund in the first fiscal year that begins after the date on which the plan is submitted;

''(ii) a description of the criteria and methods established for the distribution of funds from the State loan fund; and

''(iii) a description of the financial status of the State loan fund and the short-term and long-term goals of the State loan fund.

''(5) USE OF FUNDS.—

''(A) IN GENERAL.—Amounts deposited in a State loan fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, or as a source of reserve and security for leveraged loans, the proceeds of which

are deposited in the State loan fund established under paragraph (1). Loans under this section may be used by a health care provider to facilitate the purchase and enhance the utilization of qualified health information technology and training of personnel in the use of such technology.

''(B) LIMITATION.—Amounts received by a State under this subsection may not be used—

''(i) for the purchase or other acquisition of any health information technology system that is not a qualified health information technology system;

''(ii) to conduct activities for which Federal funds are expended under this title, or the amendments made by the Wired for Health Care Quality Act; or

''(iii) for any purpose other than making loans to eligible entities under this section.

''(6) TYPES OF ASSISTANCE.—Except as otherwise limited by applicable State law, amounts deposited into a State loan fund under this subsection may only be used for the following:

''(A) To award loans that comply with the following:

''(i) The interest rate for each loan shall be less than or equal to the market interest rate.

''(ii) The principal and interest payments on each loan shall commence not later than 1 year after the loan was awarded, and each loan shall be fully amortized not later than 10 years after the date of the loan.

''(iii) The State loan fund shall be credited with all payments of principal and interest on each loan awarded from the fund.

''(B) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

''(C) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the State if the proceeds of the sale of the bonds will be deposited into the State loan fund.

''(D) To earn interest on the amounts deposited into the State loan fund.

''(7) ADMINISTRATION OF STATE LOAN FUNDS.—

''(A) COMBINED FINANCIAL ADMINISTRATION.—A State may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with State law, the financial administration of a State loan fund established under this subsection with the financial administration of any other revolving fund established by the State if otherwise not prohibited by the law under which the State loan fund was established.

''(B) COST OF ADMINISTERING FUND.—Each State may annually use not to exceed 4 percent of the funds provided to the State under a grant under this subsection to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a State loan fund which are incurred after the date of enactment of this title.

''(C) GUIDANCE AND REGULATIONS.—The Secretary shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this subsection, including—

''(i) provisions to ensure that each State commits and expends funds allotted to the State under this subsection as efficiently as possible in accordance with this title and applicable State laws; and

''(ii) guidance to prevent waste, fraud, and abuse.

''(D) PRIVATE SECTOR CONTRIBUTIONS.—

''(i) IN GENERAL.—A State loan fund established under this subsection may accept contributions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection.

''(ii) AVAILABILITY OF INFORMATION.—A State shall make publicly available the identity of, and amount contributed by, any private sector entity under clause (i) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.

''(8) MATCHING REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary may not make a grant under paragraph (1) to a State unless the State agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash toward the costs of the State program to be implemented under the grant in an amount equal to not less than $1 for each $1 of Federal funds provided under the grant.

''(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—In determining the amount of non-Federal contributions that a State has provided pursuant to subparagraph (A), the Secretary may not include any amounts provided to the State by the Federal Government.

''(9) PREFERENCE IN AWARDING GRANTS.—The Secretary may give a preference in awarding grants under this subsection to States that adopt value-based purchasing programs to improve health care quality.

''(10) REPORTS.—The Secretary shall annually submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report summarizing the reports received by the Secretary from each State that receives a grant under this subsection.

''(c) COMPETITIVE GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.—

''(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to implement regional or local health information plans to improve health care quality and efficiency through the electronic exchange of health information pursuant to the standards, protocols, and other requirements adopted by the Secretary under sections 2903 and 2908.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

''(A) demonstrate financial need to the Secretary;

''(B) demonstrate that one of its principal missions or purposes is to use information technology to improve health care quality and efficiency;

''(C) adopt bylaws, memoranda of understanding, or other charter documents that demonstrate that the governance structure and decisionmaking processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—

''(i) physicians (as defined in section 1861(r) of the Social Security Act), including physicians that provide services to low income and underserved populations;

''(ii) hospitals (including hospitals that provide services to low income and underserved populations);

''(iii) pharmacists or pharmacies;

''(iv) health insurance plans;

''(v) health centers (as defined in section 330(b)) and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act);

''(vi) rural health clinics (as defined in section 1861(aa) of the Social Security Act);

''(vii) patient or consumer organizations;

''(viii) employers; and

''(ix) any other health care providers or other entities, as determined appropriate by the Secretary;

''(D) demonstrate the participation, to the extent practicable, of stakeholders in the electronic exchange of health information within the local or regional plan pursuant to paragraph (2)(C);

''(E) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;

''(F) adopt the standards adopted by the Secretary under section 2903;

''(G) require that health care providers receiving such grants implement the measures adopted under section 2908 and report to the Secretary on such measures;

''(H) agree to notify patients if their individually identifiable health information is wrongfully disclosed;

''(I) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas;

''(J) prepare and submit to the Secretary an application in accordance with paragraph (3); and

''(K) agree to provide matching funds in accordance with paragraph (5).

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(B) REQUIRED INFORMATION.—At a minimum, an application submitted under this paragraph shall include—

''(i) clearly identified short-term and long-term objectives of the regional or local health information plan;

''(ii) a technology plan that complies with the standards adopted under section 2903 and that includes a descriptive and reasoned estimate of costs of the hardware, software, training, and consulting services necessary to implement the regional or local health information plan;

''(iii) a strategy that includes initiatives to improve health care quality and efficiency, including the use and reporting of health care quality measures adopted under section 2908;

''(iv) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all physicians, including single physician practices and small physician groups participating in the health information plan;

''(v) a plan to ensure the privacy and security of personal health information that is consistent with Federal and State law;

''(vi) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis;

''(vii) a financial or business plan that describes—

''(I) the sustainability of the plan;

''(II) the financial costs and benefits of the plan; and

''(III) the entities to which such costs and benefits will accrue; and

''(viii) in the case of an applicant entity that is unable to demonstrate the participation of all stakeholders pursuant to paragraph (2)(C), the justification from the entity for any such nonparticipation.

''(4) USE OF FUNDS.—Amounts received under a grant under paragraph (1) shall be used to establish and implement a regional or local health information plan in accordance with this subsection.

''(5) MATCHING REQUIREMENT.—

''(A) IN GENERAL.—The Secretary may not make a grant under this subsection to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was awarded, the entity will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).

''(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under subparagraph (A) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(d) REPORTS.—Not later than 1 year after the date on which the first grant is awarded under this section, and annually thereafter during the grant period, an entity that receives a grant under this section shall submit to the Secretary a report on the activities carried out under the grant involved. Each such report shall include—

''(1) a description of the financial costs and benefits of the project involved and of the entities to which such costs and benefits accrue;

''(2) an analysis of the impact of the project on health care quality and safety;

''(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved;

''(4) a description of the efforts of recipients under this section to facilitate secure patient access to health information; and

''(5) other information as required by the Secretary.

''(e) REQUIREMENT TO ACHIEVE QUALITY IMPROVEMENT.—The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will result in the greatest improvement in quality measures under section 2908.

''(f) LIMITATION.—An eligible entity may only receive one non-renewable grant under subsection (a), one non-renewable grant under subsection (b), and one non-renewable grant under subsection (c).

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated $116,000,000 for fiscal year 2007, $141,000,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2011.

''(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2011.

''SEC. 2907. DEMONSTRATION PROGRAM TO INTEGRATE INFORMATION TECHNOLOGY INTO CLINICAL EDUCATION.

''(a) IN GENERAL.—The Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(2) submit to the Secretary a strategic plan for integrating qualified health information technology in the clinical education of health professionals and for ensuring the consistent utilization of decision support software to reduce medical errors and enhance health care quality;

''(3) be—

''(A) a health professions school;

''(B) a school of nursing; or

''(C) an institution with a graduate medical education program;

''(4) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients, the efficiency of health care delivery, and in increasing the likelihood that graduates of the grantee will adopt and incorporate health information technology, and implement the quality measures adopted under section 2908, in the delivery of health care services; and

''(5) provide matching funds in accordance with subsection (c).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—With respect to a grant under subsection (a), an eligible entity shall—

''(A) use grant funds in collaboration with 2 or more disciplines; and

''(B) use grant funds to integrate qualified health information technology into community-based clinical education.

''(2) LIMITATION.—An eligible entity shall not use amounts received under a grant under subsection (a) to purchase hardware, software, or services.

''(d) MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may award a grant to an entity under this section only if the entity agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

''(e) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable.

''(f) REPORTS.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

''(1) describes the specific projects established under this section; and

''(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.

''(h) SUNSET.—This section shall not apply after September 30, 2010.

''SEC. 2908. QUALITY MEASURES.

''(a) IN GENERAL.—The Secretary shall develop quality measures, including measures to assess the effectiveness, timeliness, patient self-management, patient centeredness, efficiency, and safety, for the purpose of measuring the quality of care patients receive.

''(b) REQUIREMENTS.—The Secretary shall ensure that the quality measures developed under this section comply with the following:

''(1) MEASURES.—

''(A) REQUIREMENTS.—In developing the quality measures under this section, the Secretary shall, to the extent feasible, ensure that—

''(i) such measures are evidence based, reliable, and valid;

''(ii) such measures are consistent with the purposes described in section 2902(b);

''(iii) such measures include measures of clinical processes and outcomes, patient experience, efficiency, and equity; and

''(iv) such measures include measures of overuse and underuse of health care items and services.

''(2) PRIORITIES.—In developing the quality measures under this section, the Secretary shall ensure that priority is given to—

''(A) measures with the greatest potential impact for improving the quality and efficiency of care provided under this Act;

''(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers; and

''(C) measures which may inform health care decisions made by consumers and patients.

''(3) RISK ADJUSTMENT.—The Secretary shall establish procedures to account for differences in patient health status, patient characteristics, and geographic location. To the extent practicable, such procedures shall recognize existing procedures.

''(4) MAINTENANCE.—The Secretary shall, as determined appropriate, but in no case more often than once during each 12-month period, update the quality measures, including through the addition of more accurate and precise measures and the retirement of existing outdated measures.

''(5) RELATIONSHIP WITH PROGRAMS UNDER THE SOCIAL SECURITY ACT.—The Secretary shall ensure that the quality measures developed under this section—

''(A) complement quality measures developed by the Secretary under programs administered by the Secretary under the Social Security Act, including programs under titles XVIII, XIX, and XXI of such Act; and

''(B) do not conflict with the needs and priorities of the programs under titles XVIII, XIX, and XXI of such Act, as set forth by the Administrator of the Centers for Medicare & Medicaid Services.

''(c) REQUIRED CONSIDERATIONS IN DEVELOPING AND UPDATING THE MEASURES.—In developing and updating the quality measures under this section, the Secretary may take into account—

''(1) any demonstration or pilot program conducted by the Secretary relating to measuring and rewarding quality and efficiency of care;

''(2) any existing activities conducted by the Secretary relating to measuring and rewarding quality and efficiency;

''(3) any existing activities conducted by private entities, including health insurance plans and payors;

''(4) the report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

''(5) issues of data collection and reporting, including the feasibility of collecting and reporting data on measures.

''(d) SOLICITATION OF ADVICE AND RECOMMENDATIONS.—On and after July 1, 2007,

the Secretary shall consult with the following regarding the development, updating, and use of quality measures developed under this section:

''(1) Health insurance plans and health care providers, including such plans and providers with experience in the care of the frail elderly and individuals with multiple complex chronic conditions, or groups representing such health insurance plans and providers.

''(2) Groups representing patients and consumers.

''(3) Purchasers and employers or groups representing purchasers or employers.

''(4) Organizations that focus on quality improvement as well as the measurement and reporting of quality measures.

''(5) Organizations that certify and license health care providers.

''(6) State government public health programs.

''(7) Individuals or entities skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment.

''(8) Individuals or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

''(9) Individuals or entities with experience with—

''(A) urban health care issues;

''(B) safety net health care issues; and

''(C) rural and frontier health care issues.

''(e) USE OF QUALITY MEASURES.—

''(1) IN GENERAL.—For purposes of activities conducted or supported by the Secretary under this Act, the Secretary shall, to the extent practicable, adopt and utilize the quality measures developed under this section.

''(2) COLLABORATIVE AGREEMENTS.—With respect to activities conducted or supported by the Secretary under this Act, the Secretary may establish collaborative agreements with private entities, including group health plans and health insurance issuers, providers, purchasers, consumer organizations, and entities receiving a grant under section 2906, to—

''(A) encourage the use of the quality measures adopted by the Secretary under this section; and

''(B) foster uniformity between the health care quality measures utilized by private entities.

''(3) REPORTING.—The Secretary shall implement procedures to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of—

''(A) quality measurement using the quality measures developed under this section and using the standards adopted by the Federal Government under section 2903; and

''(B) for reporting measures used to make value-based payments under programs under the Social Security Act.

''(f) DISSEMINATION OF INFORMATION.—Beginning on January 1, 2008, in order to make comparative quality information available to health care consumers, health professionals, public health officials, researchers, and other appropriate individuals and entities, the Secretary shall provide for the dissemination, aggregation, and analysis of quality measures collected under section 2906 and the dissemination of recommendations and best practices derived in part from such analysis.

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to public and private entities to enable such entities to—

''(1) implement and use evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety; and

''(2) establish mechanisms for the rapid dissemination of information regarding evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety.

''(h) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, from developing quality measures (and timing requirements for reporting such measures) for use under programs administered by the Secretary under the Social Security Act, including programs under titles XVIII, XIX, and XXI of such Act.''.

SEC. 3. LICENSURE AND THE ELECTRONIC EXCHANGE OF HEALTH INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study that examines—

(1) the variation among State laws that relate to the licensure, registration, and certification of medical professionals; and

(2) how such variation among State laws impacts the secure electronic exchange of health information—

(A) among the States; and

(B) between the States and the Federal Government.

(b) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall publish a report that—

(1) describes the results of the study carried out under subsection (a); and

(2) makes recommendations to States regarding the harmonization of State laws based on the results of such study.

SEC. 4. ENSURING PRIVACY AND SECURITY.

Nothing in this Act (or the amendments made by this Act) shall be construed to affect the scope, substance, or applicability of—

(1) section 264 of the Health Insurance Portability and Accountability Act of 1996;

(2) sections 1171 through 1179 of the Social Security Act; and

(3) any regulation issued pursuant to any such section.

SEC. 5. GAO STUDY.

Not later than 6 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the necessity and workability of requiring health plans (as defined in section 1171 of the Social Security Act (42 U.S.C. 1320d)), health care clearinghouses (as defined in such section 1171), and health care providers (as defined in such section 1171) who transmit health information in electronic form, to notify patients if their individually identifiable health information (as defined in such section 1171) is wrongfully disclosed.

SEC. 6. STUDY OF REIMBURSEMENT INCENTIVES.

The Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.

SEC. 7. HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.

Section 914 of the Public Health Service Act (42 U.S.C. 299b–3) is amended by adding at the end the following:

''(d) HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.—

''(1) IN GENERAL.—The Secretary, acting through the Director, shall develop a Health Information Technology Resource Center to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology in compliance with section 2903 and 2908.

''(2) PURPOSES.—The purpose of the Center is to—

''(A) provide a forum for the exchange of knowledge and experience;

''(B) accelerate the transfer of lessons learned from existing public and private sector initiatives, including those currently receiving Federal financial support;

''(C) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology.

''(D) provide for the establishment of regional and local health information networks to facilitate the development of interoperability across health care settings and improve the quality of health care;

''(E) provide for the development of solutions to barriers to the exchange of electronic health information; and

''(F) conduct other activities identified by the States, local or regional health information networks, or health care stakeholders as a focus for developing and sharing best practices.

''(3) SUPPORT FOR ACTIVITIES.—To provide support for the activities of the Center, the Director shall modify the requirements, if necessary, that apply to the National Resource Center for Health Information Technology to provide the necessary infrastructure to support the duties and activities of the Center and facilitate information exchange across the public and private sectors.

''(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the duplication of Federal efforts with respect to the establishment of the Center, regardless of whether such efforts were carried out prior to or after the enactment of this subsection.

''(e) TECHNICAL ASSISTANCE TELEPHONE NUMBER OR WEBSITE.—The Secretary shall establish a toll-free telephone number or Internet website to provide health care providers and patients with a single point of contact to—

''(1) learn about Federal grants and technical assistance services related to interoperable health information technology;

''(2) learn about qualified health information technology and the quality measures adopted by the Federal Government under sections 2903 and 2908;

''(3) learn about regional and local health information networks for assistance with health information technology; and

''(4) disseminate additional information determined by the Secretary.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2007 and 2008 to carry out this subsection.''.

SEC. 8. REAUTHORIZATION OF INCENTIVE GRANTS REGARDING TELEMEDICINE.

Section 330L(b) of the Public Health Service Act (42 U.S.C. 254c–18(b)) is amended by striking ''2002 through 2006'' and inserting ''2007 through 2011''.

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not merely a procedural vote. A vote against ordering the previous question is a vote against the Republican majority agenda and a vote to allow the opposition, at least for the moment, to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's Precedents of the House of Representatives, (VI, 308–311) describes the vote on the previous question on the rule as ''a motion to direct or control the consideration of the subject before the House being made by the Member in charge.'' To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's ruling of January 13, 1920, to the effect that ''the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition'' in order to offer an amendment. On March 15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R-Illinois) said: ''The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition.''

Because the vote today may look bad for the Republican majority they will say ''the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever.'' But that is not what they have always said. Listen to the Republican Leadership Manual on the Legislative Process in the United States House of Representatives, (6th edition, page 135). Here's how the Republicans describe the previous question vote in their own manual: Although it is generally not possible to amend the rule because the majority Member controlling the time will not yield for the purpose of offering an amendment, the same result may be achieved by voting down the previous question on the rule . . . When the motion for the previous question is defeated, control of the time passes to the Member who led the opposition to ordering the previous question. That Member, because he then controls the time, may offer an amendment to the rule, or yield for the purpose of amendment.''

Deschler's Procedure in the U.S. House of Representatives, the subchapter titled ''Amending Special Rules'' states: ''a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate.'' (Chapter 21, section 21.2) Section 21.3 continues: Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon.''

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Republican majority's agenda to offer an alternative plan.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. MATSUI. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 11 o'clock and 25 minutes a.m.), the House stood in recess subject to the call of the Chair.

□ 1202

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. SIMPSON) at 12 o'clock and 2 minutes p.m.

PROVIDING FOR CONSIDERATION OF H.R. 4157, HEALTH INFORMATION TECHNOLOGY PROMOTION ACT OF 2006

The SPEAKER pro tempore. The pending business is the vote on ordering the previous question on House Resolution 952, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for electronic voting, if ordered, on the question of adoption of the resolution.

The vote was taken by electronic device, and there were—yeas 223, nays 193, not voting 16, as follows:

[Roll No. 412]

YEAS—223

Aderholt
Akin
Alexander
Bachus
Baker
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boustany
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burton (IN)
Buyer
Calvert
Camp (MI)
Campbell (CA)
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole (OK)
Conaway
Crenshaw
Culberson
Davis (KY)
Davis, Tom
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Drake
Dreier
Duncan
Ehlers
Emerson
English (PA)
Everett
Feeney
Ferguson
Fitzpatrick (PA)
Flake
Foley
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gohmert
Goode
Goodlatte
Granger
Graves
Green (WI)
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Hulshof
Hunter
Hyde
Inglis (SC)
Inslee
Issa
Jenkins
Jindal
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kuhl (NY)
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas
Lungren, Daniel E.
Mack
Marchant
McCaul (TX)
McCotter
McCrery
McHugh
McKeon
McMorris
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Neugebauer
Ney
Northup
Norwood
Nunes
Osborne
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Poe
Pombo
Porter
Price (GA)
Pryce (OH)
Putnam
Radanovich
Ramstad
Regula
Rehberg
Reichert
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schmidt
Schwarz (MI)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Sodrel
Souder
Stearns
Sullivan
Sweeney
Tancredo
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Westmoreland
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—193

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boren
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Butterfield
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Case
Chandler
Clay
Cleaver
Clyburn
Conyers
Cooper
Costa
Costello
Cramer
Cuellar
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Edwards
Engel
Eshoo
Etheridge
Farr
Filner
Ford
Frank (MA)
Gonzalez
Gordon
Green, Al
Green, Gene
Grijalva
Gutierrez
Harman
Hastings (FL)
Herseth
Higgins
Hinchey
Hinojosa
Holden
Holt
Honda
Hooley
Hoyer
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
Kucinich
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lipinski
Lofgren, Zoe
Lowey
Lynch
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy
McCollum (MN)
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Melancon
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Schakowsky
Schiff
Schwartz (PA)
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Wasserman Schultz
Waters
Watson